Study L-4000 March 27, 1997

Memorandum 97-4

Health Care Decisions: Uniform Health-Care Decisions Act (Introduction, Advance Health-Care Directives, Miscellaneous Provisions)

At the January meeting, the Commission decided that the next step in the health care decisionmaking study should be an analysis of the Uniform Health-Care Decisions Act (1993), providing a detailed comparison to California law along with recommendations for revision. Assessing existing law primarily involves consideration of (1) the durable power of attorney for health care (DPAHC) in Probate Code Section 4600 *et seq.* and related provisions (such as the registry in Section 4800 *et seq.* and the do not resuscitate orders in Section 4753), (2) the Natural Death Act (NDA) (Health & Safety Code § 7185 *et seq.*, and (3) case law concerning health care decisionmaking by incapacitated adults. Where relevant, we will also consider the law concerning determinations of competency under Probate Code Section 810 *et seq.* and health care decisionmaking by conservators and courts. All of these tasks will not be accomplished in one memorandum or at one meeting. Several important areas such as statutory surrogacy, the statutory form, capacity determinations, and judicial proceedings will be treated in later memorandums.

Commissioners should also keep in mind that, while we are proceeding on the basis of merging the UHCDA into existing law as described above, the issue of the scope of recommended legislation is always before you. It would be possible to adopt the recommendation of the Uniform Commissioners and replace the existing DPAHC with the UHCDA. On the other end of the scale, it would be possible to adopt one or more important aspects of the UHCDA (such as statutory surrogacy) and add them to California law, but not make any significant revisions in the DPAHC or other provisions. Throughout this study we will be faced with some issues of structure and scope:

- If existing California law and the UHCDA provide a rule that is the same in substance but phrased differently, perhaps quite differently, should the existing rule be replaced? Why or why not? Is there a net gain from potential uniformity or a loss from lack of continuity and consistency within California law?

- If existing California law and the UHCDA provide inconsistent rules that do not involve major policies or fundamental structural issues, should we adopt the UHCDA rule?
- The existing rule and the UHCDA provision may be significantly inconsistent or contradictory, creating a tension between the goal of uniformity and natural presumption in favor of the existing California rule.

We have again reproduced the official text of the Uniform Health-Care Decisions Act as an Exhibit so you can get an overview of the uniform act. The following discussion will excerpt relevant portions of the act, but you will find it useful to refer to the original language in context from time to time. We hope not to reproduce the UHCDA every time this subject is on the agenda, so please retain the copy in the Exhibit for future reference.

The UHCDA covers three important types of decisionmaking, the first two of which are currently governed by statute in California: (1) "living wills" pertaining to the expression of patients' wishes in terminal or permanent unconscious condition (Natural Death Act), (2) durable powers of attorney for health care pertaining to the delegation of health care decisionmaking authority to an agent (attorney-in-fact) with or without guidelines, and (3) statutory surrogacy (also family consent law) which is governed by case law and custom. The Commission has decided to attempt to unify the relevant law to the extent desirable, using the UHCDA as the principal guide, most probably in the Probate Code. The Natural Death Act will be replaced. The existing statutory forms will be reconsidered from the ground up. Execution requirements should be simplified and made consistent and it is hoped that the two-witness rule can be retired in favor of more meaningful execution limitations, although special protections for patients in nursing homes should be retained.

The staff will also be following the efforts of other states. Thus far, only Maine and New Mexico (and maybe Delaware) have enacted the UHCDA. We will mention the variations adopted in these states where relevant. Reports from the home office of the National Conference of Commissioners on Uniform State Laws (NCCUSL) indicate that the act has been introduced in two other states this year; it appears that the act remains alive in Montana.

We do not want to get bogged down in technical issues concerning definitions at this point, but there are several important terms used in the UHCDA that affect the flavor of the act and must be understood before it can be analyzed. Adoption of several of these terms would represent a significant departure from the way we think about the options under existing California law. Rethinking the terminology should be a useful exercise, but adoption of some of these terms may cause confusion. Perhaps in a state that has little law on the subject, the uniform act would present less of a hurdle, but California has had a Natural Death Act for over 20 years (which was influential in the first Uniform Rights of the Terminally Ill Act) and has had one of the most highly developed durable power of attorney statutes for 15 years. The Health and Safety Code also contains an overlapping procedure for determining consent for patients in long-term care facilities (Section 1418.8) that will not adapt easily to the scheme of the UHCDA. On the other hand, to the extent that UHCDA terms are consistent with language used in the health care community and in federal regulations, it may be beneficial to make the switch because some of the state statutory terminology may have become outmoded.

The following discussion introduces the definitions in the UHCDA, but does not generally attempt to determine whether it should be adopted without modification.

(1) Advance health care directive; Individual instruction; Power of attorney for health care

> **UHCDA § 1(1) "Advance health-care directive"** means an individual instruction or a power of attorney for health care.

Existing California law does not use this term. The uniform act comments reports that the term "appears in the federal Patient Self-Determination Act enacted as sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990 and has gained widespread usage among health-care professionals." The name of the advance directive document is not too important, but it is probably annoying to the public, not to mention the health care and legal establishments, when the names are changed every 10 years or so. On the other hand, as the function and scope of the instrument is changed, a new name takes on a greater importance, and helps notify potential users that it is a new creature. Individuals will still be

able to execute the familiar Durable Power of Attorney for Health Care, but if the uniform act is followed, there will be a powerful Advance Health-Care Directive form that can be used for the purposes covered by the Natural Death Act and more. *The staff recommends adoption of this term and associated terms.* We make this recommendation even though the terms seem artificial and a bit jargony (but then, so is "power of attorney"), and the distinction between direction and an instruction is not readily apparent, but must be learned. The term "advance health care directive" (we intend to drop the hyphen, if possible) is also a bit wordy. This is recognized implicitly in some UHCDA provisions that omit "advance" and in some UHCDA comments that resort to the more natural "directive."

Assuming that we adopt the new language, care must be taken to include language in the definition or in another transitional section to cover existing documents such as the declaration under the Natural Death Act (Health & Safety Code § 7186(b)).

> **UHCDA § 1(9) "Individual instruction"** means an individual's direction concerning a health-care decision for the individual.

This term is somewhat confusing. To say that a person's instruction is a person's direction is not very informative. One may also wonder why the act uses both "direction" and "directive." Read literally, this definition would also include statements in powers of attorney. For now we are working on the assumption that it will all fall into place.

The UHCDA comment is more instructive:

> The term "individual instruction" (subsection (9)) includes any type of written or oral direction concerning health-care treatment. The direction may range from a written document which is intended to be effective at a future time if certain specified conditions arise …, to the written consent required before surgery is performed, to oral directions concerning care recorded in the health-care record. The instruction may relate to a particular health-care decision or to health care in general.

The staff may suggest at a future time that the definition be expanded to include some of the language in this comment.

> **UHCDA § 1(12) "Power of attorney for health care"** means the designation of an agent to make health-care decisions for the individual granting the power.

If the existing durable power of attorney for health care retains something like its current character, this definition will need to be revised.

(2) Agent

> **UHCDA § 1(2) "Agent"** means an individual designated in a power of attorney for health care to make a health-care decision for the individual granting the power.

Again we are confronted with the issue of what terminology should describe the attorney-in-fact or agent under a power of attorney. For now, the *staff recommends using "agent" as in the uniform act*, since it is generally conceded to be the more user-friendly term. The DPAHC uses both terms, preferring "attorney-in-fact" in statutes that lawyers and judges are most likely to read, and "agent" in warnings and statutory forms that are intended to be read by regular folks.

(3) Capacity

> **UHCDA § 1(3) "Capacity"** means an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision.

The UHCDA adopts a simple definition of capacity that is intended to be used and understood without the need for judicial intervention. The definition of "capacity" is fundamental, because it generally determines when the act applies. Two new and highly detailed schemes are provided in existing law for determining capacity. The Due Process in Competence Determinations Act (Prob. Code § 811 and related provisions) (DPCDA) provides a detailed set of rules for determining if a person is of unsound mind or lacks capacity to make a decision, including making medical decisions, in cases where courts are involved. Section 811 specifically provides that it does not affect the nonjudicial procedures for determining capacity in long-term care facilities under Health and Safety Code Section 1418.8 "nor increase or decrease the burdens of documentation on, or potential liability of, physicians and surgeons who, outside the judicial context, determine the capacity of patients to make a medical decision." Prob. Code § 811(e). Health and Safety Code Section 1418.8(b) provides the following capacity standard: "a resident lacks capacity to make a decision regarding his or her health care if the resident is unable to understand the nature and consequences of the proposed medical intervention, including its risks and benefits, or is unable

to express a preference regarding the intervention." We do not intend to get into the details of the capacity issues now, but this brief discussion illustrates the sort of issues that must be resolved and make clear that it would not be advisable to simply adopt the UHCDA verbatim.

(4) Health care; Health-care decision

> **UHCDA § 1(5) "Health care"** means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect an individual's physical or mental condition.
>
> **UHCDA § 1(6) "Health-care decision"** means a decision made by an individual or the individual's agent, guardian, or surrogate, regarding the individual's health care, including:
>
> (i) selection and discharge of health-care providers and institutions;
>
> (ii) approval or disapproval of diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
>
> (iii) directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care.

"Health care" is to be given the "broadest possible construction" according to the uniform act comment. Compare the definitions from the DPAHC:

> **Prob. Code § 4609. "Health care"** means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition and includes decisions affecting the principal after death.
>
> **Prob. Code § 4612. "Health care decision"** means consent, refusal of consent, or withdrawal of consent to health care, or a decision to begin, continue, increase, limit, discontinue, or not to begin any health care.

At a later point we will sort out the details of the best definition, but the basic idea behind the uniform act and existing law is to provide a very broad definition of health care.

The staff assumes that whatever broad definition is used, the NDA terms "life-sustaining treatment," "permanent unconscious condition," and terminal condition" (Health & Safety Code § 7186) will no longer be needed.

(5) Health-care institution; Health-care provider; Physician; Primary physician, Supervising health-care provider

> **UHCDA § 1(7) "Health-care institution"** means an institution, facility, or agency licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business.
>
> **UHCDA § 1(8) "Health-care provider"** means an individual licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business or practice of a profession.

Note that the UHCDA restricts "health-care provider" to an *individual*. It may not be significant, but the DPAHC and the NDA use "person" in their definitions (see Health & Safety Code § 7186(c); Prob. Code § 4615), as did the earlier uniform acts. The UHCDA uses "health care institution" to distinguish entities from individuals. We will need to make sure that these terms are not in conflict with terms used in the DPAHC and other statutes. In some situations, a generic health-care provider may have duties, such as to inform a "supervising health-care provider" of receipt of a communication revoking an advance health-care directive. UHCDA § 3(b).

> **UHCDA § 1(11) "Physician"** means an individual authorized to practice medicine [or osteopathy] under [appropriate statute].

The NDA defines physician as "a physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California." (Health & Safety Code § 7186(g).) The Probate Code does not define "physician." The DPAHC uses the term without defining it or uses the phrase "physician and surgeon" which is a term of art meaning a licensed medical doctor. It would be better to adopt the definition in the NDA and apply it to the DPAHC. The staff believes that the term "physician and surgeon" is awkward when used in these statutes and impairs the readability of already complicated statutes. In some contexts, a literal reading can lead a person to think that two signatures or approvals are required: one from a physician and one from a surgeon. (See, e.g., Prob. Code § 4753(b): "A 'request to forego resuscitative measures' shall be a written document, signed by the individual, or a legally recognized surrogate health care decisionmaker and a physician and surgeon, that directs….") Consistent and comprehensive use of the defined term "physician" as set out in Section 7186(g) should avoid these problems. Further investigation may lead to a

better expression, but *the staff recommends* using the single word "physician." Nor do we want to get into a dispute over who is qualified to act as a physician under a new act.

> **UHCDA § 1(13) "Primary physician"** means a physician designated by an individual or the individual's agent, guardian, or surrogate, to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes the responsibility.

The URTIA used "attending physician," but the UHCDA finds that

> "attending physician" could be understood to refer to any physician providing treatment to the individual, and not to the physician whom the individual, or agent, guardian, or surrogate, has designated or, in the absence of a designation, the physician who has undertaken primary responsibility for the individual's health care.

UHCDA § 1 comment. Adoption of this term depends in part on the extent to which the surrogacy rules are adopted. It is interesting to note, however, that the concept of the patient designating the responsible physician was in the original 1976 California NDA, which included language defining "attending physician" as the physician "selected by, or assigned to, the patient." (Former Health & Safety Code § 7187(a).) This phrase was omitted when the NDA was revised in 1991 for greater consistency with the 1989 URTIA. Now the concept is back in the UHCDA definition of "primary physician."

> **UHCDA § 1(16) "Supervising health-care provider"** means the primary physician or, if there is no primary physician or the primary physician is not reasonably available, the health-care provider who has undertaken primary responsibility for an individual's health care.

According to the UHCDA comment, the "supervising health-care provider" concept "accommodates the circumstance that frequently arises where care or supervision by a physician may not be readily available. The individual's primary physician is to assume the role, however, if reasonably available." Thus, for example, a supervising health-care provider is to be given notice of revocation (UHCDA § 3(a)) and must perform certain record-keeping functions (UHCDA § 7).

(6) Reasonably available

> **UHCDA § 1(14) "Reasonably available"** means readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient's health-care needs.

This term is used in the definitions of "primary physician" and "supervising health-care provider" and also plays a crucial role in determining whether a statutory surrogate can act in place of an agent or guardian or a patient-designated or higher-ranking surrogate under UHCDA Section 5.

(7) Surrogate

> **UHCDA § 1(17) "Surrogate"** means an individual, other than a patient's agent or guardian, authorized under this [Act] to make a health-care decision for the patient.

The UHCDA comments amplifies:

> The definition of "surrogate" … refers to the individual having present authority under Section 5 to make a health-care decision for a patient. It does not include an individual who might have such authority under a given set of circumstances which have not occurred.

As noted above, we are reserving the issues concerning health care decisionmaking by surrogates for a later memorandum.

(8) Miscellaneous Terms

The UHCDA also defines guardian, person, and state. These terms will be superseded by general terms used in the Probate Code.

CREATION AND EFFECT OF ADVANCE HEALTH-CARE DIRECTIVE

Section 2 of the Uniform Health-Care Decisions Act provides the basic rules concerning execution, contents, and the effect of advance health-care directives. The UHCDA is structured so that some rules apply to one or the other class of advance health care directives (individual instructions or powers of attorney), some rules apply to both classes of directives, and some rules depend on whether the directive is written (distinguishing between written individual instructions and powers of attorney, on one hand, and oral individual instructions on the

other). The categories are not mutually exclusive; e.g., written advance directives are subject oral revocation.

Individual Instruction

The UHCDA covers a lot of ground in three short sentences:

> **UHCDA § 2(a)** An adult or emancipated minor may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.

California does not generally provide for what the UHCDA calls an "individual instruction" other than through the mechanism of the Natural Death Act, in terminal or permanent unconscious cases, and in the context of appointing and instructing an attorney-in-fact under a DPAHC. (Of course, there are numerous references in the statutory and case law to an individual's right to determine his or her health care.) It has been reported that people may execute a DPAHC without appointing an attorney-in-fact so that they can use that vehicle to state their health care instructions. It is also possible to appoint an attorney-in-fact in a DPAHC but limit the authority while expressing broad health care instructions. A "living will" may also be given effect by custom without any validating statute. *The staff recommends* adopting the principle of the UHCDA to make the law clearer and easier to use. The instructions option should be clearly implemented as part of a statutory form and enabled for private forms.

The formulation of who may execute a power of attorney (and by analogy, an individual instruction) was given a fair amount of consideration when the Power of Attorney Law was under preparation. Probate Code Section 4120 provides: "A natural person having the capacity to contract may execute a power of attorney." And Section 4022 defines power of attorney, in part, as an instrument "executed by a natural person having the capacity to contract." This language makes references to emancipated minors unnecessary, and *the staff recommends* that this approach be continued, although there may be a better way to say it than in Section 4120. The existing PAL does not use the word "adult" except in reference to witness qualifications. See Sections 4122, 4703, 4771 (statutory form). The NDA provides for execution of a declaration governing the withholding or withdrawal of life-sustaining treatment by an "individual of sound mind and 18 or more years of age." Health & Safety Code § 7186.5(a).

The UHCDA does not directly require that the person executing an advance directive have capacity. However, UHCDA Section 11(b) provides that an "individual is presumed to have capacity … to give or revoke an advance health-care directive…." The comment states that this is a rebuttable presumption. In addition, health care providers and institutions are protected for acting in good faith and in accordance with generally accepted health care standards for complying with advance directives and "assuming that the directive was valid when made." UHCDA § 9(a)(3). Both Maine and New Mexico have added requirements that the person executing an individual instruction have capacity. Maine has also limited the effect of oral instructions so that they are valid only if made to a health-care provider or a person who can serve as a surrogate. New Mexico is even more restrictive, validating oral instructions only if made by personally informing a health-care provider. *The staff has not formulated a recommendation on this point*, but would like to hear the views of interested persons and groups.

Power of Attorney Execution and Effect

> **UHCDA § 2(b)** An adult or emancipated minor may execute a power of attorney for health care, which may authorize the agent to make any health-care decision the principal could have made while having capacity. The power must be in writing and signed by the principal. The power remains in effect notwithstanding the principal's later incapacity and may include individual instructions. Unless related to the principal by blood, marriage, or adoption, an agent may not be an owner, operator, or employee of [a residential long-term health-care institution] at which the principal is receiving care.

Again, the UHCDA provides a very efficient statement of some essential principles governing the durable power of attorney for health care. It is difficult to imagine, however, that we could acceptably replace the much more detailed California rules with such a brief statement, regardless of the virtues of such an approach. The rules in existing law are there because they were determined to be necessary or beneficial at some time in the not too distant past.

Who may execute power of attorney. The same issues concerning who may execute a power of attorney that are considered above in connection with individual instructions apply here. There are inconsistencies in existing statutes concerning who can execute particular documents. The goal should be to have uniform rules to the extent possible and appropriate. Section 7186.5(a) in the

NDA, for example, is limited to persons age 18 and over. As noted above, however, the DPAHC, relies on the general power of attorney rules permitting execution by any person with the capacity to contract, thus incorporating the rules concerning emancipated minors. See generally Fam. Code §§ 6500 *et seq.* (minors), 7000 *et seq.* (Emancipation of Minors Law), 7050(e)(1) (consent to medical care), (e)(2) (delegation of power); Prob. Code §§ 4121, 4700. (As noted in an earlier memorandum, the *staff does not recommend considering issues relating to health care decisionmaking for unemancipated minors.*) The UHCDA refers to "an adult or emancipated minor." In California, the law relating to emancipated minors should take care of itself, and explicit statutory reference should not be necessary, but in this area of the law, it should be clear and consistent.

Agent's authority. The standard in the first sentence concerning the basic authority of the agent should not say that the agent can make a decision that the principal "could have made," but rather "could make," as in the following rule from the DPAHC (Prob. Code § 4720(b)):

> (b) Subject to any limitations in the durable power of attorney, the attorney-in-fact designated in a durable power of attorney for health care may make health care decisions for the principal, before or after the death of the principal, **to the same extent as the principal could make health care decisions if the principal had the capacity to do so**, including the following:
>
> (1) Making a disposition under the Uniform Anatomical Gift Act (Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code).
>
> (2) Authorizing an autopsy under Section 7113 of the Health and Safety Code.
>
> (3) Directing the disposition of remains under Section 7100 of the Health and Safety Code.

The staff also thinks that the additional detail of existing law, which dates back to the original California DPAHC enacted on Commission recommendation, should be retained unless there is a convincing reason to eliminate it. We do not believe that it must be continued in this form, but making clear that the attorney-in-fact has authority to make dispositions effective post-death is important and helps link this statute to the others, both substantively and in the minds of the persons who use the statute and forms created to implement it.

Both the UHCDA and the DPAHC overstate the authority of the agent, which is subject to certain limitations expressed elsewhere. Section 13(c) of the UHCDA

provides: "This [Act] does not authorize mercy killing, assisted suicide, euthanasia, or the provision, withholding, or withdrawal of health care, to the extent prohibited by other statutes of this State."

Probate Code Section 4722 prohibits authorization of the following in a DPAHC:

> (a) Commitment to or placement in a mental health treatment facility.
> (b) Convulsive treatment (as defined in Section 5325 of the Welfare and Institutions Code).
> (c) Psychosurgery (as defined in Section 5325 of the Welfare and Institutions Code).
> (d) Sterilization.
> (e) Abortion.

In addition, Section 4723 provides, similarly to the UHCDA:

> 4723. Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than the withholding or withdrawal of health care pursuant to a durable power of attorney for health care so as to permit the natural process of dying. In making health care decisions under a durable power of attorney for health care, an attempted suicide by the principal shall not be construed to indicate a desire of the principal that health care treatment be restricted or inhibited.

The staff does not intend to review these exceptions at this stage. Consider, however, whether some of these limitations might be unconstitutional. Section 4723 reflects language of the older Natural Death Act and for that reason should be reconsidered. Whether that should be attempted in the course of this study and by the Commission are issues on which the staff would appreciate commentary.

Execution formalities — witnessing. The second sentence of UHCDA requires a power of attorney to be in writing and signed by the principal, but does not require any witnesses or notarization. Note, however, that the "Optional Form" in UHCDA Section 4 encourages the use of witnesses by providing a place for signatures. Obviously there is no limitation on who may be an optional witness. The two-witness requirement is fairly standard for important documents in California. For example, a DPAHC under the general rules may be notarized *or* signed by two witnesses, whereas the *statutory form* DPAHC requires two witnesses. Compare Prob. Code §§ 4700(b) & 4121(c) with § 4773. The request to

forego resuscitative measures (the DNR "do not resuscitate" form) is signed by the individual (or "legally recognized surrogate health care decisionmaker") and a physician. Prob. Code § 4753(b). The NDA declaration requires two witnesses.

At the January meeting, the Commission decided to pursue the possibility of eliminating the two-witness requirement. This would mean the elimination of provisions such as the following in the Natural Death Act (Health & Safety Code 7186.5(a)):

> The declaration shall be signed by the declarant, or another at the declarant's direction and in the declarant's presence, and witnessed by two individuals at least one of whom may not be a person who is entitled to any portion of the estate of the qualified patient upon his or her death under any will or codicil thereto of the qualified patient existing at the time of execution of the declaration or by operation of law.

The Commission also concluded at the January meeting that some protective rules for patients in skilled nursing facilities and long-term heath care facilities should probably be retained. See, e.g., Prob. Code § 4701(e).

The uniform act aims to effectuate the individual's intent without relying too much on execution formalities. The drafters viewed formalities as unnecessarily inhibiting while at the same time doing "little, if anything, to prevent fraud or enhance reliability." English & Meisel, *Uniform Health-Care Decisions Act Gives New Guidance,* Est. Plan. 355, 358-59 (Dec. 1994). The genuineness of advance directives is bolstered by placing reliance on the health care providers as a general rule, although, as noted, witnesses are encouraged in the form. The act relies on recordkeeping — entering the advance directive in the patient's health care records — and conformance with medical ethics as affirmative rules to determine and effectuate genuine intent, and provides that anyone

> who intentionally falsifies, forges, conceals, defaces, or obliterates an individual's advance health-care directive or a revocation of an advance health-care directive without the individual's consent, or who coerces or fraudulently induces an individual to give, revoke, or not to give an advance health-care directive, is subject to liability to that individual for damages of $[2,500] or actual damages resulting from the action, whichever is greater, plus reasonable attorney's fees. [UHCDA § 10(b).]

The UHCDA approach was adopted in New Mexico, but Maine has added a two-witness requirement in its version of the UHCDA.

Who may be an agent. The last sentence of UHCDA Section (2)(b) precludes owners, operators and employees of long-term care institutions where the principal is receiving care from acting as agents under a power of attorney unless related by blood, marriage or adoption. Section 4702 in the DPAHC provides a more extensive list of exclusions:

> 4702. (a) Except as provided in subdivision (b), the following persons may not exercise authority to make health care decisions under a durable power of attorney:
>
> (1) The treating health care provider or an employee of the treating health care provider.
>
> (2) An operator or employee of a community care facility.
>
> (3) An operator or employee of a residential care facility for the elderly.
>
> (b) An employee of the treating health care provider or an employee of an operator of a community care facility or an employee of a residential care facility for the elderly may be designated as the attorney-in-fact to make health care decisions under a durable power of attorney for health care if both of the following requirements are met:
>
> (1) The employee is a relative of the principal by blood, marriage, or adoption, or the employee is employed by the same treating health care provider, community care facility, or residential care facility for the elderly that employs the principal.
>
> (2) The other requirements of this chapter are satisfied.
>
> (c) Except as provided in subdivision (b), if a health care provider becomes the principal's treating health care provider, the health care provider or an employee of the health care provider may not exercise authority to make health care decisions under a durable power of attorney.
>
> (d) A conservator may not be designated as the attorney-in-fact to make health care decisions under a durable power of attorney for health care executed by a person who is a conservatee under the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), unless all of the following are satisfied:
>
> (1) The power of attorney is otherwise valid.
>
> (2) The conservatee is represented by legal counsel.
>
> (3) The lawyer representing the conservatee signs a certificate stating in substance:
>
> "I am a lawyer authorized to practice law in the state where this power of attorney was executed, and the principal was my client at the time this power of attorney was executed. I have advised my client concerning his or her rights in connection with this power of

> attorney and the applicable law and the consequences of signing or not signing this power of attorney, and my client, after being so advised, has executed this power of attorney."

This section has been the subject of very careful scrutiny over the years, and was last amended in 1995. *The staff would be reluctant to recommend its replacement* by the UHCDA provision, although it is appealingly brief and easy to understand.

When Agent's Authority Is Effective

> **UHCDA § 2(c)** Unless otherwise specified in a power of attorney for health care, the authority of an agent becomes effective only upon a determination that the principal lacks capacity, and ceases to be effective upon a determination that the principal has recovered capacity.

This provision adopts a general rule that powers of attorney for health care are "springing powers" — i.e., powers that become effective only when the principal cannot act. Note that the UHCDA permits the power of attorney to provide otherwise. The uniform act comment states:

> A principal may provide, however, that the authority of the agent becomes effective immediately or upon the happening of some event other than the loss of capacity but may do so only by an express provision in the power of attorney. For example, a mother who does not want to make her own health-care decisions but prefers that her daughter make them for her may specify that the daughter as agent is to have authority to make health-care decisions immediately. The mother in that circumstance retains the right to later revoke the power of attorney as provided in Section 3.

Probate Code Section 4720(a) adopts a similar approach:

> 4720. (a) Unless the durable power of attorney provides otherwise, the attorney-in-fact designated in a durable power of attorney for health care who is known to the health care provider to be available and willing to make health care decisions has priority over any other person to act for the principal in all matters of health care decisions, but the attorney-in-fact does not have authority to make a particular health care decision if the principal is able to give informed consent with respect to that decision.

It occurs to the staff that Section 4720(a) is susceptible of two interpretations, depending on whether one reads the introductory "unless" clause as overriding the ending "but" clause, or reads the "but" clause as supreme. The Commission Comment makes the intent clear, however:

> The power of attorney may, however, give the attorney-in-fact authority to make health care decisions for the principal even though the principal is able to give informed consent, but the power of attorney is always subject to Section 4724 (if principal objects, attorney-in-fact not authorized to consent to health care or to the withholding or withdrawal of health care necessary to keep the principal alive).

The staff is troubled by the notion that a competent individual can effectively delegate present health care decisionmaking authority to another. We would be interested to hear from the experts in the medical field about whether this occurs now, how this works or should work, and whether it is a good policy. The staff suspects that the reason the rule is stated in such a roundabout way is that the law really does not want to permit agents to make decisions for competent patients, but the possibility is recognized as a way to prevent second-guessing of decisions where it is not clear whether the principal was competent.

Agent's Acceptance

The UHCDA does not provide any direct rules concerning the duty of the agent to act or implement any procedures for acceptance of the duties under a power of attorney. The Power of Attorney Law provides that an attorney-in-fact does not have a duty to act unless there is an express agreement in writing to act for the principal. Prob. Code § 4230; see also Section 4720 Comment. The UHCDA commentary to the optional form encourages use of an acceptance in the following terms:

> Formal acceptance by an agent has been omitted not because it is an undesirable practice but because it would add another stage to executing an advance health-care directive, thereby further reducing the number of individuals who will follow through and create directives. However, practitioners who wish to adapt this form for use by their clients are strongly encouraged to add a formal acceptance. Designated agents have no duty to act until they accept the office either expressly or through their conduct. Consequently, requiring formal acceptance reduces the risk that a designated agent will decline to act when the need arises. Formal acceptance also makes it more likely that the agent will become familiar with the principal's personal values and views on health care. While the form does not require formal acceptance, the explanation to the form does encourage principals to talk to the person they have named as agent to make certain that the

> designated agent understands their wishes and is willing to take the responsibility.

This is a difficult issue to address by statute, as the Commission learned in working on Section 4230 in the PAL. If it is important to implement a principle such as "acceptance through conduct" as advocated in the UHCDA comment, it should be stated in the statute so there is no doubt about the rule's existence. *The staff would either leave the existing California rule as it is* or if a revise it as needed, but not leave the matter to a comment. The staff does agree that the form, when we get to that stage, should probably not be further complicated by providing for a formal acceptance with attendant warnings. One goal of this project should be to simplify the existing statutory form, replace it with a simple form like that provided in the UHCDA, or leave form drafting to others, such as the California Medical Association.

Determination of Capacity

> **UHCDA § 2(d)** Unless otherwise specified in a written advance health-care directive, a determination that an individual lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent, must be made by the primary physician.

This is a practical rule affirming the reality of the physician-patient relationship. In daily experience, the medical professionals will make the necessary capacity determinations and the approach of the UHCDA is to avoid or minimize any need to obtain formal capacity determinations by courts. As with other aspects of the UHCDA, there is a specific record-keeping duty imposed on determinations of capacity and a duty to communicate to the patient and anyone else with decisionmaking authority. See UHCDA § 7(c). Of course, the determination of capacity and other triggering conditions are subject to control in the power of attorney. California does not provide any explicit rule of this nature as far as we are aware; the implicit approach of the DPAHC is to rely on good-faith determinations by the health care provider and attorney-in-fact and confirmation of the identity and status of the attorney-in-fact. (See, e.g., Prob. Code §§ 4750, 4751.). *The staff recommends adoption of the UHCDA rule and its associated recordkeeping and reporting standards.*

Maine clarifies that the determination under its version of UHCDA Section 2(d) must be made by the primary physician "or a court of competent

jurisdiction." This language recognizes reality, of course, but might be objectionable if it undermines the purpose of the UHCDA to avoid judicial intervention unless necessary.

New Mexico has pulled several of the capacity-related provisions into a single section and cross-refers to it in its Section 2(d). Among other things, that procedure requires determinations of capacity or the existence of other conditions triggering a power of attorney to be made by "two qualified health-care professionals," one of whom is the primary physician. This is reminiscent of the qualifications applicable under California's Natural Death Act (Health & Safety Code § 7187.5):

> A declaration becomes operative when (a) it is communicated to the attending physician and (b) the declarant is diagnosed and certified in writing by the attending physician and a second physician who has personally examined the declarant to be in a terminal condition or permanent unconscious condition and no longer able to make decisions regarding administration of life-sustaining treatment.

The NDA was amended to state this rule in 1991.

Agent's Duty To Follow Instructions

> **UHCDA § 2(e)** An agent shall make a health-care decision in accordance with the principal's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the agent's determination of the principal's best interest. In determining the principal's best interest, the agent shall consider the principal's personal values to the extent known to the agent.

This is, of course, the fundamental rule governing conduct of agents. It is the fiduciary principal adapted to the health care decisionmaking context. Probate Code Section 4720(c) in the DPAHC provides a similar rule:

> (c) In exercising the authority under the durable power of attorney for health care, the attorney-in-fact has a duty to act consistent with the desires of the principal as expressed in the durable power of attorney or otherwise made known to the attorney-in-fact at any time or, if the principal's desires are unknown, to act in the best interests of the principal.

The suggestion was made at the January Commission meeting that if existing law and the UHCDA have inconsistent rules, but other factors are equal, the

presumption should be in favor of adopting the UHCDA language. This is different from our usual approach which favors continuity of existing rules unless there is a reason to change. In this case, the UHCDA provision states directly that the agent determines the principal's best interest and that the principal's values known to the agent are to be considered. This appears to be a more subjective standard than the DPAHC rule requiring the attorney-in-fact to act in the principal's best interests (which could be interpreted as an objective standard) and does not refer to the personal values of the principal. On balance, *the staff prefers the UHCDA rule.*

Judicial Involvement

> **UHCDA § 2(f)** A health-care decision made by an agent for a principal is effective without judicial approval.

This provision implements the same general policy as Section 4900 in the Power of Attorney Law: "A power of attorney is exercisable free of judicial intervention, subject to this part." The UHCDA statement is more direct and applies specifically to health care decisions, whereas the PAL provision is a general rule applying to all powers of attorney, not just health care powers. *The staff thinks it would be beneficial to include the UHCDA rule.*

Nomination of Conservator

> **UHCDA § 2(g)** A written advance health-care directive may include the individual's nomination of a guardian of the person.

Section 4126 in the Power of Attorney Law provides a far more detailed rule applicable to all powers of attorney. *The staff would keep the existing rule* but add authority in Section 4126 or elsewhere for nomination of a guardian or conservator by means of a written individual instruction.

Validating Provision

> **UHCDA § 2(h)** An advance health-care directive is valid for purposes of this [Act] if it complies with this [Act], regardless of when or where executed or communicated.

According to the comment, this provision applies to directives executed before the UHCDA was enacted in the jurisdiction, as well as to instruments executed in other jurisdictions.

California law has detailed and highly confusing transitional provisions concerning the validity of earlier statutory form powers of attorney for health care and other instruments. Sorting through those rules will be left for another time. But as to foreign instruments (there is no rule on oral instructions in existing law), the DPAHC provides:

> 4653. A durable power of attorney for health care or similar instrument executed in another state or jurisdiction in compliance with the laws of that state or jurisdiction or of this state, shall be valid and enforceable in this state to the same extent as a durable power of attorney for health care validly executed in this state.
>
> 4752. In the absence of knowledge to the contrary, a physician and surgeon or other health care provider may presume that a durable power of attorney for health care or similar instrument, whether executed in another state or jurisdiction or in this state, is valid.

Section 4653 requires a determination that an instrument complies with the law of this or some other state or jurisdiction. This is technically broader than the UHCDA rule, which requires compliance with its own requirements, but since the UHCDA execution requirements are so minimal, it is not likely to invalidate foreign state directives in many cases. Still the California rule goes farther and validates instruments that could fail under the UHCDA rule, such as where a technical witnessing rule is not complied with. Note that the NDA provides the same rule concerning withholding or withdrawal of life-sustaining treatment. Health & Safety Code § 7192.5. *The staff sees no reason to retreat* from the existing California rule. It is consistent in spirit with the UHCDA rule and also protects the policy from later amendments that might defeat the UHCDA approach. New Mexico did not include subdivision (h) in its UHCDA; Maine added a provision as in California law making the directive valid if it complies with the law of the state where executed.

On the other hand, some may conclude that the existing policy is too broad and should be reevaluated. The UHCDA rule at least makes sure that its minimal standards are satisfied (although it is not clear at this point that California would adopt the minimal standards as a general rule), whereas the California rule could theoretically avoid any limitations in the interest of granting full comity to standards of other jurisdictions.

> **UHCDA § 8.** Unless otherwise specified in an advance health-care directive, a person then authorized to make health-care decisions for a patient has the same rights as the patient to request, receive, examine, copy, and consent to the disclosure of medical or any other health-care information.

Under the UHCDA, an agent, guardian, or surrogate stands in the shoes of the patient and has full access to patient records unless the right is restricted by an advance directive.

Section 4721 in the DPAHC provides the same right, but in different terms:

> 4721. Except to the extent the right is limited by the durable power of attorney for health care, an attorney-in-fact designated to make health care decisions under a durable power of attorney for health care has the same right as the principal to receive information regarding the proposed health care, to receive and review medical records, and to consent to the disclosure of medical records.

In effect, the UHCDA rule is broader because it applies one rule to all types of persons authorized to make decisions under the act and the "unless" clause is not limited to powers of attorney. Read literally, the UHCDA rule would seem to permit an oral individual instruction (a type of advance directive) to limit the ability of an agent under a power of attorney or a court-appointed conservator to obtain records. This is probably consistent with the revocation rules under Section 4727, which allow a principal to revoke a DPAHC or the attorney-in-fact's authority either orally or in writing. For this purpose, the principal is presumed to have capacity. But we doubt that existing law would allow a conservatee to preclude access to medical records by a conservator. *The staff believes* that a broader rule will be needed to cover the expanded concept of advance health care directives, but that the UHCDA does not make some necessary distinctions. We will do more research on the issue and consider alternatives when we prepare a draft statute for Commission consideration. We will also consider the impact of other rules, such as Health and Safety Code Section 123100 which distinguishes between the individual's right to his or her own records and the right of "persons having responsibility for decisions respecting the health of others." The latter class "in general" has "access to

information on the patient's condition and care," whereas individuals have a right to "complete information respecting his or her condition and care."

As time permits, we will present the other major parts of the UHCDA — relating to surrogacy, the "optional" form, and the obligations and immunities of health care providers. After preliminary policy decisions and directions are made, the staff will be in a position to put a rough draft together for more detailed consideration.

Respectfully submitted,

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